AUSTRALIAN GOVERNMENT

Safety, Rehabilitation and Compensation Amendments (Improving the Comcare Scheme) Bill 2015

Regulation Impact Statement

Department of Employment

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1. Background

The *Safety, Rehabilitation and Compensation Act 1988* (SRC Act) provides rehabilitation and workers' compensation arrangements for Commonwealth and Australian Capital Territory (ACT) Government employees as well as employees of 33 licensed corporations comprising current and former Commonwealth authorities and approved private corporations. The SRC Act also applies to members of the Australian Defence Force (ADF) who were injured before 1 July 2004 during non-operational service[1].

Australian Government agencies and statutory authorities (excluding members of the ADF) and ACT Government agencies and authorities pay premiums to Comcare under the SRC Act (premium payers). The SRC Act also enables current and former Commonwealth authorities, and private corporations who can demonstrate that they are in competition with a current or former Commonwealth authority, to seek a licence to self-insure for workers' compensation purposes under the SRC Act (self-insurers or licensees). Comcare determines and manages claims lodged by the employees of premium payers. Licensees determine and manage claims lodged by their own employees. Claims for ADF members under the SRC Act are managed by the Department of Veterans' Affairs.

Comcare operates on a cost-recovery basis for premium payers and licensees and does not receive Budget funding for these services. Comcare receives, via the Department of Employment, annual and special appropriations for pre-1989 workers' compensation claims. All expenses associated with post-1989 Comcare-managed workers' compensation claims are fully cost recovered through premiums paid by Commonwealth and ACT Government agencies.

A licence provides eligible corporations the authority to manage and bear the costs and risks of workers' compensation claims submitted by their own employees. The arrangement for private sector corporations to have coverage for workers' compensation under the SRC Act was introduced to provide competitive neutrality for those corporations competing in the market with government business enterprises – such as Optus competing in telecommunications business with Telstra and TNT Australia competing in the freight business with Australia Post.

For the purposes of the SRC Act, determinations, decisions or requirements under specific sections of the Act are made by Comcare, licensees and the Department of Veterans' Affairs and they are collectively referred to as determining authorities.

As at the end of the 2012-13 financial year, about 57 per cent of all employees covered under the SRC Act were employed by premium payers, and the remaining 43 per cent by licensees.[2] The proportion of employees employed by self-insurers is significantly higher under the SRC Act than in any other jurisdiction. The percentage of employees covered by self-insurers in New South Wales is 24 per cent; in Victoria 6.1 per cent; in Queensland 9 per cent; in Western Australia 9.3 per cent; in

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[1] ADF members injured on or after 1 July 2004 are covered by the *Military Rehabilitation and Compensation Act 2004*

[2] Comcare Annual Report 2012-2013, p. 65

Tasmania 4.7 per cent; in the Northern Territory 3.7 per cent; and in the Australian Capital Territory less than 1 per cent.[3]

There have been numerous ad-hoc changes since the SRC Act was enacted in 1988. However, it is the department's view that it no longer reflects current best practice or community expectations. In 2012-13, reviews of the SRC Act were undertaken by Mr Peter Hanks QC and Dr Allan Hawke AC. Mr Hanks reviewed the SRC Act's workers' compensation benefit structures, rehabilitation and return-to-work provisions. Dr Hawke reviewed the performance of workers' compensation under the SRC Act, in particular the governance and financial frameworks. The terms of reference did not enable consideration of any reduction in existing benefits afforded to workers covered under the SRC Act.

Mr Hanks and Dr Hawke consulted extensively and engaged with participants in the workers' compensation process under the SRC Act to assist in the development of the recommendations. The participants consulted included employer associations and employers, employee organisations, medical practitioners, rehabilitation professionals, lawyers and other professionals, government agencies, licensees and workers' compensation administrators. Stakeholders were extensively involved in the identification of issues, through to the development of recommendations and consulted again post-publication of the recommendations. The Report on the Review of the SRC Act was released in March 2013; however, no further action was taken under the previous Government.

The Government has developed a two stage process to reform the SRC Act, which includes recommendations made by Mr Hanks and Dr Hawke. The department has also consulted widely to develop the package of reforms and reviewed state and territory workers' compensation schemes in detail, including recent changes in New South Wales and Queensland. The first stage of reform focussed on expanding eligibility for companies to self-insure under the SRC Act and reducing red tape as part of the application process. This culminated in the Safety, Rehabilitation and Compensation Legislation Amendment Bill 2014 (the Bill) which was introduced into Parliament on 19 March 2014 and passed the House of Representative on 26 November 2014 and is currently before the Senate. If passed, the amendments in the Bill will open up workers' compensation under the SRC Act to national employers by removing the competition test and enabling corporations operating and employing in two or more states and territories to self-insure under the SRC Act and have coverage under the Commonwealth's work health and safety regime. The amendments will also enable group licences to be issued to an eligible group of corporations. The amendments will exclude compensation for injuries occurring during recess breaks away from work and injuries resulting from serious and wilful misconduct.

This Regulation Impact Statement (RIS) examines the second stage of the Government's reforms to the SRC Act. The amendments will improve the operation of workers' compensation under the SRC Act by improving return-to-work outcomes for injured workers; improving the focus on early intervention and health outcomes of injured workers; and improving administration of the scheme. They will also reduce red tape and compliance costs.

[3] Comparison of Workers' Compensation Arrangements in Australia and New Zealand, July 2013, p. 156

2. Description and scope of the problem

The SRC Act was designed with one employer in mind, the Australian Public Service, and it was introduced at a time when employment conditions (including the administrative arrangements around employment, superannuation conditions and other entitlements) were relatively consistent across a workforce that was engaged in generally similar types of work.[4]

This environment has changed significantly over the past 26 years. As at 1 July 2014, there were 212 Australian and ACT Government premium payers and 30 licensed corporations covered by the SRC Act. Of all fulltime equivalent employees covered under the SRC Act, 216 082 were employed by premium payers and 161 153 were employed by licensees.[5]

It is estimated that approximately 80 large employing businesses (with operations in five states or territories) will seek coverage under the SRC Act following the removal of the competition test. It is further assumed that, on a yearly basis, an average 12 businesses of the 80 would seek a licence under the SRC Act.

The shift in the employment profile has already resulted in the SRC Act becoming out of step with current working conditions and best practice in rehabilitation and health issues. Consequently, the incentives, or disincentives, currently provided to employees and employers to facilitate an early return-to-work are not always suitable for today's workforce.

The current legislative framework for medical treatment does not align with recent changes to the regulation of health practitioners in Australia and limits Comcare's ability to have appropriate oversight and control over the treatment it is funding. Additionally, no formal training is required for the provision of in-home care which does not provide the injured worker the best possible chance of recovery and care is not linked to the level of impairment which can result in less injured employees being provided services that are not commensurate with the level of injury. Furthermore the legislation does not benefit from contemporary evidence on the benefits of work.

Disputes under the Comcare scheme generally take more time to resolve than disputes in other jurisdictions. In the Comcare scheme only 13.7 per cent of disputes are resolved within three months; this compares to 85.1 per cent in Queensland, 81.9 per cent in Western Australia and 70.1 per cent in Tasmania[6]. This is despite Comcare spending on average the same amount of its total expenditure on dispute resolution (1.2 per cent) as other jurisdictions[7].

Compared to licensees under the SRC Act, premium paying employers are less successful with achieving early and sustained return-to-work for their employees. Over a nine year period, return-to-work rates have fallen from the mid to high eighties (reaching 89 per cent in 2005-06) to plateau at 80-81 per cent in the last four years. While Comcare's 2012-13 return-to-work rate of 80 per cent is higher than or equal to other jurisdictions (New South Wales' is 80 per cent, Tasmania's is 79 per

[4] *Safety, Rehabilitation and Compensation Act Review Report*—February 2013, Peter Hanks QC, p. 23. Available at: http://docs.employment.gov.au/node/31849

[5] Comcare Annual Report 2012-2013 p. 65

[6] Safe Work Australia's Comparative Performance Monitoring Report, 16th Edition, p.34

[7] Safe Work Australia's Comparative Performance Monitoring Report, 16th Edition, p. 29

cent, Victoria's is 77 per cent, Queensland and Western Australia's is 75 per cent and South Australia's is 70 per cent[8]) it has been on a downward trajectory with no indications of improvement.

The cost of all claims under the SRC Act during 2012-13 was $540 million, which is an increase of 11 per cent from 2011-12[9]. The types of claims lodged under the SRC Act have also changed over time, with a significant increase in time off work for mental stress claims. This has contributed to claim costs increasing by 37 per cent in the five years to 2012-13[10].

Premiums charged to Commonwealth agencies have increased by more than 50 per cent over the past four years. Comcare's asset to liability ratio, that is, the adequacy of the scheme to meet future claim payments, was quite low at 66 per cent in 2012-13. This compares unfavourably with Queensland at 156 per cent, Victoria at 125 per cent and New South Wales at 118 per cent[11].

3. Objectives

The objective of this package of reforms is to modernise the SRC Act to emphasise the vocational (rather than medical) nature of rehabilitation services and improve return-to-work outcomes under the scheme; to promote fairness and equity in outcomes of injured employees by targeting support to those who need it most; and to strengthen the integrity and viability of the scheme.

4. Overview of this Regulation Impact Statement

This RIS deals with the overall regulatory impact of the Government's second stage of reforms. These will modernise the SRC Act to reflect the current working environment and remuneration arrangements, promote expectations of evidence-based medical care and encourage early rehabilitation and return-to-work of injured employees.

Given the complex linkages and interdependencies of the reform package, the regulatory impact of each amendment cannot be assessed individually but is considered as a whole. To allow for meaningful assessment, the reforms have been categorised in a manner that is consistent with the implementation of the reform package. The categorisation of these measures follows four themes: income replacement; evidence based medical treatment; household and attendant care; and medical and legal costs.

Many of the amendments relate to government processes and will not have any regulatory impact on businesses or the not-for profit sector. Other changes are likely to have only a minor impact on businesses. Consistent with the Australian Government Guide to Regulation, this RIS examines those amendments that are likely to have an impact on businesses, but not those that are minor or machinery in nature or do not substantially alter existing arrangements.

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[8] Safe Work Australia's Comparative Performance Monitoring Report, 16th Edition, p. 31

[9] Comcare Annual Report 2012-2013 p. 65

[10] Compendium of WHS and Workers' Compensation Statistics, December 2013, p. 52

[11] Safe Work Australia's Comparative Performance Monitoring Report, 16th Edition, p. 26

4.1. Other Matters

There are a range of other matters not specifically examined in this RIS which are contained in the second stage of the government's reforms to the SRC Act. Most are matters with no regulatory impact and those matters that have a regulatory impact are minor or machinery in nature and therefore do not substantially alter existing regulatory arrangements.

These amendments align eligibility criteria for both physical and mental injuries with state and territory schemes and community standards; ensure a stronger focus on rehabilitation and return-to-work; provide early access to rehabilitation and medical treatment; reform the process of assessment and compensation of permanent impairment; and improve the administrative efficiency of workers' compensation under the SRC Act.

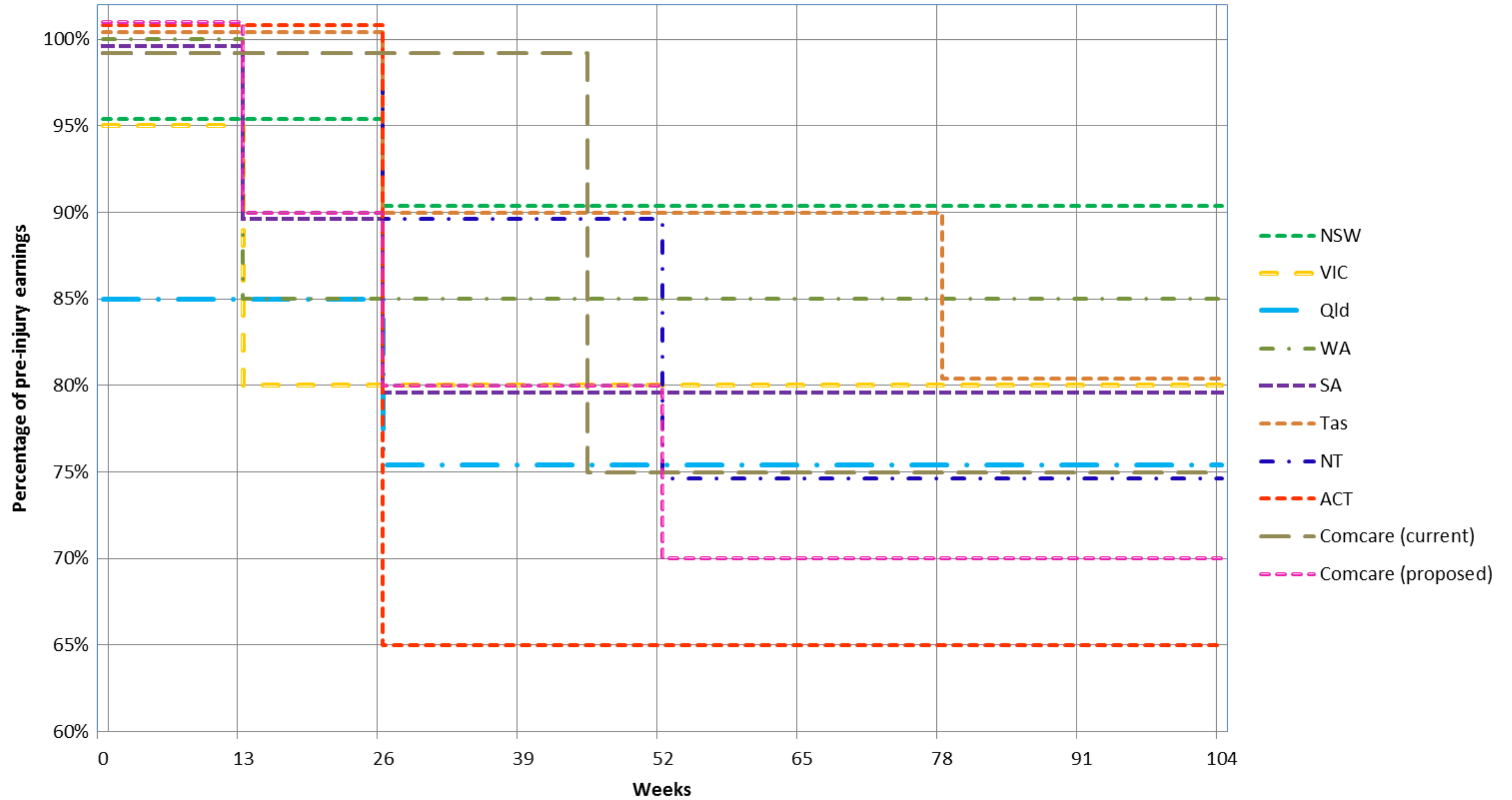
5. Income Replacement

5.1. The Problem

All Australian workers' compensation schemes reduce the proportion of income replacement over time; this is called a 'step-down'. The step-down provides an incentive for employees to return-to-work as quickly as possible as well as recognising the need to manage compensation costs. Under the SRC Act, income replacement benefits are paid at 100 per cent of pre-injury normal weekly earnings (NWE) for the first 45 weeks, after which they reduce to 75 per cent of pre-injury NWE for as long as income replacement is payable. This provides the unintended incentive for injured employees to stay at home. The evidence is clear that the longer employees are away from work, the less likely it is they will return-to-work[12]. This is undesirable and unintended.

In most state and territory workers' compensation schemes, there is more than one step-down for incapacity payments, with the first occurring relatively early in the life of a claim. In Victoria, South Australia and Western Australia, the first step-down occurs after 13 weeks. All other states and territories initiate the first step-down after 26 weeks. By contrast, the only step-down in the SRC Act occurs much later, at 45 weeks.

[12] Johnson, D., Fry T. Factors Affecting Return to Work after Injury: A study for the Victorian WorkCover Authority. Melbourne: Melbourne Institute of Applied Economic and Social Research; 2002. Referenced by the Australasian Faculty of Occupational & Environmental Medicine *Realising the Health Benefits of Work: A Position Statement.* 2011: Royal Australian College of Physicians. Page 12.



Comparison of step-down in incapacity entitlements - total incapacity
Percentage of pre-injury earnings
100%
95%
90%
85%
80%
75%
70%
65%
60%
0
13
26
39
52
65
78
91
104
Weeks
NSW
VIC
Qld
WA
SA
Tas
NT
ACT
Comcare (current)
Comcare (proposed)

Many states providing entitlements after the first step-down do so subject to limitations on the sum of entitlement and require a stipulated degree of impairment or a cap on the total of entitlements payable. Such restrictions do not apply under Comcare's long-tail scheme which provides incapacity payments until age 65 and compensation for medical treatment and rehabilitation for life.

The existing late step-down in the Comcare scheme may create a disincentive for early return-to-work by injured employees and increases costs. This is consistent with the international evidence, for example, Meyer, Viscusi and Durbin found that return-to-work rates decreased when Michigan and Kentucky increased the amount they paid higher income injured workers. The rate was steady for other workers (whose payments did not change). The authors found '…substantial labour-supply effects of workers' compensation benefits[13].'

A sizeable body of empirical work has accumulated over the past 40 years (particularly over the last decade) in which epidemiologists and multi-disciplinary researchers have investigated the possible link between the recovery and health outcomes of an injured person based on whether or not they are potentially eligible to pursue compensation. The majority of studies and, indeed, systematic reviews of such studies, find a link between various measures of an injured person's compensation status and worse health outcomes.[14]

A 2002 actuarial study found that if an injured employee is off work for 20 days, their chance if ever getting back to work is 70 per cent, after 45 days this falls to 50 per cent and after 70 days the chance of ever returning to work is only 35 per cent[15].

Apart from step-downs, there is a further reduction in income replacement when an employee accesses their superannuation before age 65. At this point, the SRC Act offsets the compensation payable to an employee who has retired early and received a superannuation pension and/or a lump sum benefit in two ways:

- reducing the amount of compensation payable to the employee by deducting the amount of superannuation that is derived from the employer's contribution (to prevent double-dipping of benefits and ensuring that these employees do not receive a higher take-home pay than they had before their injuries); and
- reducing the amount of compensation payable to the employee by a further 5 per cent of the employee's pre-injury earnings, being representative of the amount the employee would have contributed to superannuation.

The 5 per cent reduction has attracted considerable criticism over a number of years on the grounds that it discriminates against the most severely injured and vulnerable employees. At the same time, it has been ineffective as an incentive in returning people to the workforce.

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[13] Meyer, B.D., Viscusi, W.K., & Durbin, D.L. *Workers' Compensation and Injury Duration: Evidence from a Natural Experiment* from Vol. 85, No. 3 of the American Economic Review, June 1995, page. 322.

[14] Appendix J, Productivity Commission Inquiry Report: Disability Care and Support, July 2011 Volume 1, p. J. 1

[15] Johnson, D., Fry T. Factors Affecting Return to Work after Injury: A study for the Victorian WorkCover Authority. Melbourne: Melbourne Institute of Applied Economic and Social Research; 2002. Referenced by the Australasian Faculty of Occupational & Environmental Medicine *Realising the Health Benefits of Work: A Position Statement.* 2011: Royal Australian College of Physicians. Page 12.

Under current provisions, where an employee is undergoing a partial return-to-work, the period of the step-down varies according to the number of hours worked. This operates to extend the 45 week period before the step-down is applied. For example, if an injured employee is at work for 50 per cent of their pre-injury hours (rather than completely off work) then, currently, the step-down period runs for double the time it does for those employees who are completely off work (90 weeks instead of 45 weeks).

This approach is inconsistent with that taken in the states and territories, which count any incapacity in a week as a whole week of incapacity. Under the states' arrangements, an employee who was incapacitated for one day in, say, each of ten weeks, would have those ten days counted as ten weeks towards the next step-down. In contrast, the SRC Act step-down arrangement would have only offset ten days against the 45 weeks and would then allow access to a further 43 weeks of incapacity entitlements at 100 per cent of NWE. This further reduces the effectiveness of the step-down arrangements and acts as a disincentive for early return-to-work.

5.2. Options

5.2.1. Option One — Maintain the status quo

Under this option, incapacity payments will continue to be provided at 100 per cent of NWE for a period of 45 weeks, after which they will step down to 75 per cent for as long as income replacement is payable. The amount of incapacity benefits paid to employees who have retired and receive a superannuation pension and/or a lump sum will continue to be reduced by a further 5 per cent of the employee's pre-injury earnings. The current provisions also add a layer of complexity when introducing variations to the step-down arrangements for injured employees who have made a partial return-to-work. This is because after the step-down to 75 per cent of NWE, if an injured employee returns to work on a part-time basis their incapacity payments will be topped up by an amount commensurate with their part-time hours.

5.2.2. Option Two — The Hanks Review Recommendations - Three-level system for stepping down income replacement benefits

The Hanks Review preferred recommendation proposes three step-downs:

- 100 per cent of NWE for the first 13 weeks of incapacity for work;
- 90 per cent of NWE during weeks 14-26 of incapacity for work; and
- 80 percent of NWE thereafter.

Any week when the employee is participating in a return-to-work program, or absent from work for any reason other than undergoing medical treatment of the compensable condition, will be counted for the purposes of the step-down provisions. The 5 per cent reduction in incapacity benefits to injured employees who have retired and received their superannuation before age 65 will be removed.

5.2.3. Option Three — Four-level system for stepping down income replacement benefits

This was one of the models considered in the Hanks Review. It proposes four step-downs:

- 100 per cent of NWE during the first 13 weeks of incapacity for work;

- 90 per cent of NWE during weeks 14-26 of incapacity for work;
- 80 per cent of NWE during weeks 27-52 of incapacity for work; and
- 70 per cent of NWE thereafter.

If the employee returns to work after 26 weeks, even on a part-time basis, their income will be topped up to 90 per cent of NWE as an incentive to return-to-work.

Any week when the employee is participating in a return-to-work program, or absent from work for any reason other than undergoing medical treatment of the compensable condition, will be counted for the purposes of the step-down provisions. The 5 per cent reduction in incapacity benefits to injured employees who have retired and received their superannuation before age 65 will be removed.

5.2.4. Option Four - ACT system - Two level system for stepping down income replacement benefits

This option is based on the model used in the ACT. It proposes two step-downs:

- 100 per cent of NWE for the first 26 weeks of incapacity for work; and
- 65 percent of NWE thereafter.

Any week when the employee is participating in a return-to-work program or absent from work for any reason other than undergoing medical treatment of the compensable condition, will be counted for the purposes of the step-down provisions. The 5 per cent reduction in incapacity benefits to injured employees who have retired and received their superannuation before age 65 will be removed.

5.3. Impact Analysis

This impact analysis considers the impact of the changes beyond the status quo.

5.3.1. Option Two — The Hanks Review Recommendations - Three-level system for stepping down income replacement benefits

This option was recommended by Hanks because it shifts the balance of expenditure on compensation from short-term to long-term incapacitated employees and better recognises the needs of that second group. It also provides significant incentives for employees to pursue rehabilitation and return-to-work at an early stage when rehabilitation has the best prospects of success. Under this option, injured employees with long term incapacity will receive a higher level of income replacement than is currently the case.

This option was based on the terms of reference for that Review that stipulated there be no reduction in incapacity benefits. Consequently, this option will increase the current cost of incapacity entitlements for long-term injured employees and is opposed by employers.

Impacts on Employers

Step-down provisions will generate increased productive capacity for employers by encouraging injured employees back to work sooner, even if on a part-time basis. Employers will also be required to increase their focus on providing suitable employment for employees able to return-to-work early.

This option will lead to a small amount of downward pressure on premiums for premium payers (a saving of $6.2 million across the Commonwealth and ACT Government per year), a nominal decrease in claims costs for licensees (a saving of $2.7 million across all licensees per year[16]).

Impacts on Employees

There is compelling evidence that, for most individuals, working improves general health and wellbeing and reduces psychological distress. This is better for the employee, their family, the workplace and the community[17].

Step-down provisions are an effective incentive to encourage injured employees to return-to-work. Increasing the number of step-downs and bringing these forward will result in a greater motivation to return-to-work earlier for many injured employees.

Although 85 per cent of employees receiving income replacement have returned to work after 13 weeks of incapacity[18], those remaining will receive less income replacement (90 per cent, then 80 per cent after 26 weeks, rather than the current 100 per cent) as a result of this amendment. However, injured employees who receive income replacement for longer than 45 weeks will not be worse off under this option as, after 26 weeks, they will receive 80 per cent of their income for the duration of their incapacity, compared to 75 per cent of their income which is currently paid. This is in line with the terms of reference of the Hanks Review which stipulated that there be no reduction in benefits for injured employees.

5.3.2. Option Three — Four-level system for stepping down income replacement benefits

This model applies similar principles to Option Two in that it encourages injured employees with a shorter recovery time to return-to-work while still recognising the financial needs of the long-term incapacitated by providing a generous level of income replacement (70 per cent) until the employee is able to return-to-work or reaches retirement age.

As with Option Two, the 5 per cent reduction in incapacity benefits to injured employees who have retired and received their superannuation before age 65 will be removed. As a consequence, the final step-down to 70 per cent provides the employee with the same level of income replacement as currently applies for this cohort of injured employees (i.e. 75 per cent less 5 per cent = 70 per cent).

Injured employees who return-to-work after 26 weeks, even on a part-time basis, will have their income topped up to 90 per cent of NWE as an added incentive to return-to-work.

In the Comcare scheme, evidence shows that injured workers who are off work for between 13 to 45 weeks are less likely to return-to-work and stay in work than other injured workers.[19]

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[16] Taylor Fry Actuarial Costings requested for Review of the Safety, Rehabilitation and Compensation Act 1988 Summary Report, 8 February 2013, Appendix C of the Safety, Rehabilitation and Compensation Act Review Report - February 2013, pp. 219-230.

[17] Australian and New Zealand Consensus Statement on the Health Benefits of Work, p. 7

[18] Data provided by Comcare on return to work performance for 2012-13

[19] Comcare, *SRCC and Comcare Annual Reports 2013-14*. Canberra. Page 75.

Together, the four-level system of step-downs and counting any week when the employee is absent from work as a week of compensation will provide a significantly stronger incentive than current arrangements for employees to return-to-work as quickly as possible.

Data provided by Comcare on its return-to-work performance for the financial year 2012-13 is as follows:

Period of Absence	Less than 1 week	1 week or more	12 weeks or more	45 weeks or more	52 weeks or more
Percentage of employees receiving compensation	58%	42%	15%	4%	3%

Impacts on Employer

Step-down provisions will generate increased productivity for employers by encouraging injured employees back to work sooner, even if on a part-time basis. Employers will also be required to increase their focus on providing suitable employment for employees able to return-to-work early.

This option will lead to downward pressure on premiums for premium payers (a saving for the Commonwealth and ACT Government of approximately $45 million per year), a reduction in claim costs for licensees (a saving of $14 million across licensees per year[20]), and will reduce the overall cost of workers' compensation for all employers under the SRC Act.

Impacts on Employees

There is compelling evidence that, for most individuals, working improves general health and wellbeing and reduces psychological distress. This is better for the employee, their family, the workplace and the community[21].

Step-down provisions are an effective incentive to encourage injured employees to return-to-work. Increasing the number of step-downs and bringing these forward will result in a greater incentive to return-to-work earlier for many injured employees. This incentive to return-to-work will be enhanced after 26 weeks when injured employees will have their incapacity payments topped up to 90 per cent of NWE if they return-to-work, even if on a part-time basis.

Although 85 per cent of employees receiving income replacement have returned to work after 13 weeks of incapacity, the remaining 15 per cent will receive less income replacement[22] (90 per cent, then 80 per cent after 26 weeks, rather than the current 100 per cent) as a result of this amendment. Injured employees who are receiving income replacement for more than 52 weeks will be better off from weeks 45 to 52 as they will receive 80 per cent of the pre injury income rather than 75 per cent, as is currently the case. However the four per cent of injured employees who receive income replacement for 52 weeks or more will receive five per cent less under this option

[20] Taylor Fry Actuarial costing of the impact of proposed changes to the Safety, Rehabilitation and Compensation Act 1988, 8 July 2014, p. 10.

[21] Australian and New Zealand Consensus Statement on the Health Benefits of Work, p. 7

[22] Data provided by Comcare on return to work performance for 2012-13

than is currently the case. Under current arrangements, if an injured employee accesses their superannuation before age 65, their income replacement is reduced by five per cent, resulting in income replacement equal to 75 per cent. Therefore, these employees would receive the same amount of income replacement after 52 weeks under this option as they currently do.

5.3.3. *Option Four - ACT system - Two level system for stepping down income replacement benefits*

This model has a greater focus on compensation for short-term incapacitated employees who make up the vast majority of workers' compensation claims. However, long-term incapacitated employees will receive less under this option than is currently the case. As these employees are generally the most severely injured, this scenario is less than ideal.

As with Options Two and Three, the five per cent reduction in incapacity benefits to injured employees who have retired and received their superannuation before age 65 will be removed.

The two-level system of step-downs, with a significant drop in income replacement after 26 weeks, will provide a stronger incentive for employees to return-to-work as quickly as possible.

Impacts on Employer

Step-down provisions will generate increased productive capacity for employers by encouraging injured employees back to work sooner. Employers will also be required to increase their focus on providing suitable employment for employees able to return-to-work early.

This option will lead to downward pressure on premiums for premium payers, a reduction in licencing costs for licensees and will reduce the overall cost of workers' compensation for all employers under the SRC Act.

Impacts on Employees

There is compelling evidence that, for most individuals, working improves general health and wellbeing and reduces psychological distress. This is better for the employee, their family, the workplace and the community[23].

Step-down provisions are an effective incentive to encourage injured employees to return-to-work. However, as evidence suggests that the majority of injured employees have returned to work after 26 weeks, this option does not provide an incentive for these employees.

Approximately four to fifteen per cent of employees are receiving income replacement after 26 weeks[24]. These employees will face a significant drop in their income replacement from 100 per cent to 65 per cent of their pre-injury earnings. This is compared to the 100 per cent of pre-injury earnings they would receive after 26 weeks of incapacity under current arrangements. Injured employees with a long term incapacity for work will also receive less for the duration of their incapacity; 65 per cent instead of 75 per cent, as is currently the case.

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[23] Australian and New Zealand Consensus Statement on the Health Benefits of Work, p. 7

[24] Data provided by Comcare on return to work performance for 2012-13

5.4. Consultation

In response to the recommendations put forward by Mr Hanks in his review of the SRC Act, stakeholders provided the following comments:

Telstra indicated its support generally but believed the final step-down should remain at 75 per cent rather than the 80 per cent proposed by Mr Hanks. [Note: The Review's Terms of Reference stipulated that there be no reduction in existing benefits.]

The Australian Chamber of Commerce and Industry supported the introduction of four levels of step-downs but suggested the incentive to return-to-work should commence from date of injury; that is, compensation start at 90 per cent of NWE rather than 100 per cent.

Some licensees believed that the proposed system of step-downs would not offer enough motivation for injured employees to return-to-work and believed a statutory rate should be imposed after one year of income replacement. Other licensees believed the proposed changes (Option 3) were a significant improvement on current arrangements and would be an effective tool to encourage injured employees back to work. Some licensees also believed that counting any period of incapacity as a week of incapacity for the purpose of step-downs could be too harsh.

Premium payers were also very supportive of the proposed changes, indicating that the new step-downs would provide a stronger incentive for injured employees to return-to-work while containing escalating claim costs.

The Australian Council of Trade Unions opposed step-down provisions generally and submitted that injured employees should be compensated with a 100 per cent replacement of lost income indefinitely. They believed the proposal was punishing people for being injured and forcing them back to work by shifting costs from the employer to the employee.

The Australian Manufacturing Workers' Union also opposed changes to step-down provisions, indicating they should remain at their current timing and levels.

5.5. Conclusion

The department recommends Option Three as it provides a stronger incentive for injured employees to return-to-work earlier by reducing income replacement payments sooner and more frequently than is currently the case. This package of amendments also includes the added incentive after 26 weeks of 'topping up' income replacement to 90 per cent if the employee returns to work, even if on a part-time basis. It also rectifies anomalies and outdated provisions in the SRC Act such as counting each day of absence individually so that the current 45 week step-down can be dragged out for years.

There is compelling evidence that, for most individuals, working improves general health and wellbeing and reduces psychological distress. This is better for the employee, their family, the workplace and the community[25].

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[25] Australian and New Zealand Consensus Statement on the Health Benefits of Work, p. 7

This option will better align income replacement provisions under the SRC Act with state and territory schemes by introducing multiple step downs at an earlier stage in the claim. As these schemes represent the vast majority of employees, better alignment with these schemes should accord with community standards and expectations. This option will also generate increased productivity for businesses and reduced administration for determining authorities. It will lead to downward pressure on premiums for premium payers and will reduce the overall cost of workers' compensation for all employers under the SRC Act.

6. Evidence based medical treatment

6.1. The Problem

The framework in the SRC Act for the provision and monitoring of medical treatment is not clearly defined or in alignment with current best practice across state and territory workers' compensation schemes. The lack of a modern framework for regulating the provision of these services under the SRC Act is producing barriers to timely and effective recovery and return-to-work, in addition to imposing increased costs.

Standard of medical treatment

Under the SRC Act, a determining authority[26] has no involvement in, or control over, an injured employee's choice of medical or therapeutic practitioner or treatment. Requirements need to be put in place to ensure that funds are used appropriately for the provision of medical treatment and the services provided are in line with accepted best practice.

Under the SRC Act, a determining authority is liable to pay compensation in respect of medical treatment that is 'reasonable' for an injured employee to obtain. There have been many legal cases over the years that have considered 'reasonable' medical treatment, as this is not defined under the SRC Act. In each case, what is 'reasonable' has been determined by reference to the employee's individual circumstances and perspective.

This has resulted in case law that works against the original intent of the SRC Act such as:

- The Administrative Appeals Tribunal (AAT) approving the continuation of massage therapy payments as part of a broader treatment plan, despite no evidence of any curative effect associated with the massage therapy in this case. This cost $29,000 over an eight-year period.
- The AAT finding it was reasonable for an injured employee living in Alice Springs (who had 'generalised anxiety disorder and adjustment reaction with brief depressive reaction') to attend a Buddhist meditation retreat in Queensland, at taxpayer expense, because he identified as a Buddhist.
- The AAT finding it was reasonable for an employee to be flown from Canberra to Townsville to receive psychoneuroimmunology treatment after the clinical nurse psychotherapist

[26] A Determining Authority, whether Comcare, a Commonwealth authority, a licensed authority or a licensed corporation, is able to make determinations, decisions or requirements under specific sections of the SRC Act.

providing the treatment relocated. This relatively new and unique form of treatment was not offered by anyone else in Canberra.

In June 2012, Comcare, along with all state and territory workers’ compensation schemes, endorsed the National Clinical Framework, which is based on a document published in 2005 by WorkSafe Victoria and the Victorian Transport Accident Commission. The National Clinical Framework is an evidence-based policy framework that outlines a set of five guiding principles for the delivery of allied health services to injured employees. The guiding principles of the Clinical Framework require:

- measurement and demonstration of the effectiveness of treatment;
- adoption of a bio-psycho-social approach - this approach explains how, in general, work is good for health and wellbeing. ‘Bio’ describes the impairment, body structure and function elements; ‘psycho’ describes the activity, support and relationship elements; and ‘social’ describes the participation elements;
- empowering the injured person to manage their own injury;
- implementing goals focused on optimising function, participation and return-to-work; and
- basing treatment on best available research evidence.

A full adoption of the National Clinical Framework and the resulting benefits of timely and effective return-to-work are being undermined by the current provisions in the SRC Act. The SRC Act does not define standards of medical treatment, whether provided in Australia or overseas, nor does it require that health providers’ qualifications be accredited by the appropriate professional body or by Comcare.

Medical treatment provided by ‘legally qualified health practitioners’

According to the Australian and New Zealand Consensus Statement on the Health Benefits of Work, employees attempting to return-to-work after a period of injury face a complex situation with many variables. Good outcomes are more likely when employees understand the health benefits of work and are empowered to take responsibility for their own recovery. Health practitioners exert a significant influence on work absence and in promoting the health benefits of work[27].

Other state and territory workers’ compensation schemes maintain a level of oversight and control over the medical treatment they are funding in different ways:

- In Victoria, service providers such as chiropractors, dentists, psychologists and physiotherapists, must be registered with WorkSafe Victoria to provide services to injured employees. Providers must complete a ‘WorkSafe Application for Registration to Provide Services to Workers’ form and must satisfy the relevant provider eligibility requirements. Medical practitioners registered under Medicare are not required to register separately with WorkSafe.

[27] Australian and New Zealand Consensus Statement on the Health Benefits of Work, p. 7

- In New South Wales, allied health providers must be approved as WorkCover providers and follow administrative procedures developed by WorkCover in conjunction with the relevant professional association.

Registration standards, such as those in Victoria and New South Wales, provide an extra layer of risk control that is currently lacking under the SRC Act.

Although the definition of 'medical treatment' under the SRC Act refers to eight types of treatment, it does not prescribe a level of national accreditation required for these practitioners in line with current protocols under the National Accreditation and Registration Scheme for health providers.

In its current form, the SRC Act's definition of medical treatment does not enable Comcare to maintain a level of oversight and control over the medical treatment it is funding thereby exposing injured employees to treatment, both within Australia and overseas, that is not evidence based or provided by trained health professionals.

The SRC Act is also out of step with current regulatory practice in the states and territories as it does not recognise the 'National Registration and Accreditation Scheme' and its registration and regulation requirements.

The 'National Registration and Accreditation Scheme' for registered health practitioners was established by the Council of Australian Governments in 2008. Under the 'National Registration and Accreditation Scheme', 14 health professions are regulated by National Boards and must meet set standards in order to be registered to practise in Australia. The 14 National Boards are supported by the Australian Practitioner Regulation Agency.

For those injured employees who are required to seek medical treatment whilst overseas, there is no provision in the SRC Act for relevant determining authorities to review the qualifications of overseas health care providers or the standard of treatment provided. Compensation for these costs must be paid if the need for the treatment is considered reasonable, no matter the standard of treatment provided or the qualifications of those providing it.

The SRC Act also has no provisions to enable determining authorities to refer health practitioners to the appropriate professional regulatory body where treatment is provided outside the Clinical Framework, or where there are concerns about the adequacy, appropriateness or frequency of treatment.

Provision of medicines

The definition of 'medical treatment' under section 4(1) of the SRC Act allows for the provision of 'medicines … whether in a hospital or otherwise'. The definition of what constitutes 'medicine' under the SRC Act has been compromised beyond the common understanding of that term by court decisions between 1996 and 2006, where 'medicine' has been deemed to include packaged dietary foods, vitamin and mineral supplements and non-prescription medicines such as analgesics. Compensation for the cost of 'medicines' under state and territory schemes is restricted to medicines recommended or prescribed by a medical practitioner or dentist.

Some prescription medicines, such as drugs that are addictive (schedule 8 opioids and schedule 4 sedatives), are subject to misuse and abuse that may result in death or serious damage to health. In addition, there is a risk that some injured employees may visit multiple general practitioners in order to obtain more prescription medicines than is clinically necessary or safe for the treatment of their

condition (doctor shopping). Unregulated payment of compensation for these treatments and prescriptions finances these behaviours.

Comcare's Clinical Panel pharmacist reviews all pharmacy billed items (invoices). Pharmacy or supermarket receipts (injured employee reimbursement) are not currently reviewed. The pharmacist pays particular attention to drugs of concern, including that they have one prescriber and one dispenser.

The pharmacist estimates the following:

- Schedule 8 (opioids) comprise about 25-30 per cent of the invoices reviewed.
- Including schedule 4 sedatives (benzos), the estimate is increased to around 40 per cent of invoices that contain both opioids and/or sedatives.

Since the establishment of Comcare's Pharmacy Policy on 1 February 2012, Comcare has identified 87 claims of concern and written to the treating doctors of those injured employees.

Other workers' compensation schemes in Australia, such as Victoria, require prescription medicines to be dispensed by a registered pharmacist on the request of a legally qualified medical practitioner or legally qualified dentist.

6.2. Options

6.2.1. Option One — Maintain the status quo

As demonstrated, retaining the status quo will continue to pose additional costs as a result of non-evidence based treatments that are provided by untrained health practitioners, or by health practitioners who are not meeting accepted standards in their treatments, with little recourse for restricting compensation for that treatment. The current approach does not focus on return-to-work and its benefits for injured employees.

Currently, under the SRC Act, there is no recourse to refer health practitioners to their professional regulatory bodies if a practitioner is found not to be adhering to standards set by the Clinical Framework in the provision of treatment. Additionally, for those injured employees who are overseas, treatment providers and the provision of treatment will continue to be compensated no matter the standard of treatment provided or the qualifications of those providing it.

Determining authorities are also currently required to individually assess each claim to determine whether medical treatment provided is reasonable. As each determination is influenced by the employee's individual circumstances, this process is administratively inefficient and poses additional costs.

Retaining the status quo will therefore inhibit access to effective evidence based medical treatment.

6.2.2. Option Two — Restrictions on compensation for prescription medicines; medical treatment must meet objective standards to be compensable, be provided by a legally qualified health practitioner or overseas equivalent or recognised and accredited by Comcare

Under this option, the definition of 'medical treatment' in the SRC Act will be amended so that, in order to be compensable, medical treatment must meet objective standards, such as those in the Clinical Framework, and must be provided by health practitioners who are accredited and registered

under the ‘National Registration and Accreditation Scheme’. This option will also enable Comcare to consider and accredit those not registered under the Accreditation Scheme for eligibility to provide medical treatment under the SRC Act. This will ensure that medical treatment obtained is measurable and outcome focussed.

In addition, the SRC Act will be amended to include treatment provided outside Australia only where the determining authority is satisfied that the quality and cost of that treatment is comparable with treatment available in Australia provided by a health practitioner registered under the National Registration and Accreditation Scheme or recognised and accredited by Comcare.

Amendments to the SRC Act will provide for the referral of practitioners to the appropriate professional regulatory bodies where treatment falls outside the principles of the Clinical Framework, or where there are concerns about the adequacy, appropriateness or frequency of treatment.

This option will also amend the definition of ‘medical treatment’ in the SRC Act to restrict compensation for ‘medicines’ to medicines recommended or prescribed by legally qualified medical practitioners or dentists (or under some circumstances a legally qualified optometrist or nurse) and provided by a legally qualified pharmacist. In addition, compensation for drugs of addiction will be restricted to those prescribed by the employee’s nominated ‘legally qualified medical practitioner’.

The employee will nominate a specific legally qualified medical practitioner at the outset of their claim and will be able to change the nomination throughout the life of the claim. An employee will only be able to have one nominated legally qualified medical practitioner at any one time.

This option is consistent with the recommendations put forward by Mr Hanks in his review of the SRC Act in 2012.

6.2.3. Option Three - Cap on the lifetime costs of a claim, adoption of the National Clinical Framework, medical treatment to be provided by an Allied Health Provider or Comcare approved medical providers (based on WA model)

This option is based on current practice in Western Australia and has several similarities to Option Two presented above. Like Option Two, this option will require medical treatment to be provided by health practitioners who are accredited and registered under the ‘National Registration and Accreditation Scheme’ in order to be compensable. Comcare will also have the ability to consider and accredit those not registered under the Accreditation Scheme for eligibility to provide medical treatment under the SRC Act.

The National Clinical Framework will also be adopted to provide an evidence-based policy framework for the delivery of health services to injured employees and compensation for ‘medicines’ will be restricted to prescription medicines only.

A cap on the lifetime costs of a claim will also be implemented which will help to reduce and/or stabilise rising costs.

6.3. Impact Analysis

This impact analysis considers the impact of the changes beyond the status quo.

6.3.1. Option Two — Restrictions on compensation for prescription medicines; medical treatment must meet objective standards to be compensable, be

provided by a legally qualified health practitioner or overseas equivalent or recognised and accredited by Comcare.

Impacts on Employers

Determining authorities, including licensees, will notice a minor reduction in regulatory burden as they will no longer be required to interpret whether medical treatment is reasonable in every situation. Instead, they will be required to ensure that medical treatment is provided by legally qualified health practitioners and in accordance with objective standards such as those in the Clinical Framework. Each determining authority will be able to determine how they assess whether medical treatment meets objective standards; for example, by requiring the provision of a treatment plan. Where treatment is provided outside the principles of the Clinical Framework, or where there are concerns about the adequacy, appropriateness or frequency of treatment, determining authorities will be able to refer practitioners to the appropriate professional regulatory body.

Health providers which are not registered under the 'National Registration and Accreditation Scheme' will be assessed and accredited by Comcare on a national basis rather than as individuals. This will impose no additional regulatory burden on premium payers or licensees.

As the party responsible for reimbursing the cost of medications, determining authorities are exposed to risks, such as injured employees doctor shopping, illegally selling or overusing medications, exacerbated injuries or even potential fatalities of employees. Legislating the conditions relating to the SRC Act's reimbursement of medications will reduce risk to both injured employees and determining authorities.

Under this option, an employee will be required to nominate a legally qualified medical practitioner for the purpose of prescribing medications classified as drugs of addiction. Determining authorities will need to ensure that compensation is only paid for drugs of addiction prescribed by the employee's nominated legally qualified medical practitioner.

Impacts on health providers

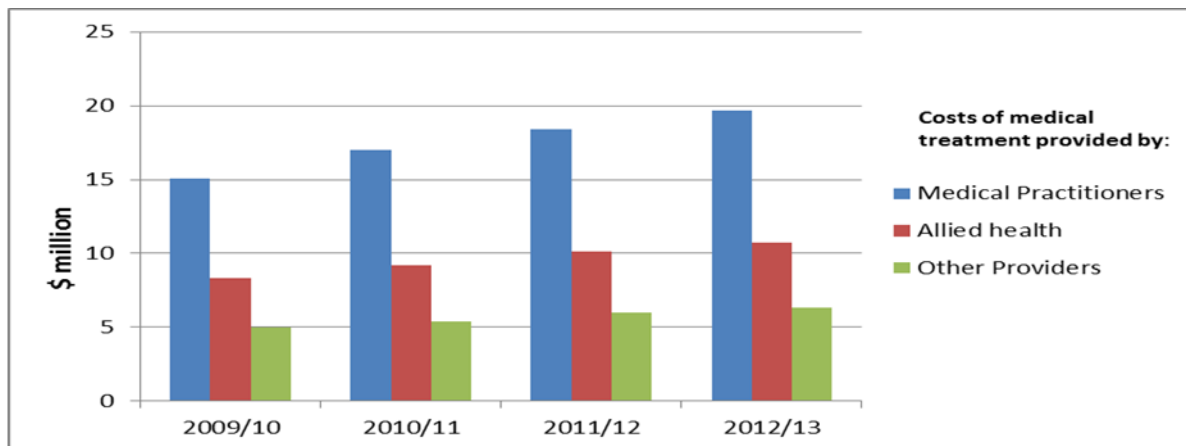
Health providers registered under the National Registration and Accreditation Scheme are regulated by 14 National Boards that set the standards that practitioners must meet and manage complaints about the health, conduct or performance of practitioners. Each National Board has also set a code of conduct and ethics that seek to assist and support practitioners to deliver appropriate, effective services within an ethical framework. Practitioners have a professional responsibility to be familiar with their relevant code and to apply the guidance it contains.

The ability of determining authorities to improve accountability in regards to treatment outcomes, for example, by requiring the development of a treatment plan, will place an additional reporting burden on health professionals. The referral of those professionals not meeting appropriate standards to the relevant National Board or professional regulatory body will also place an additional reporting burden on health professionals. However, any additional reporting burden should be minimal for providers registered under the National Registration and Accreditation Scheme due to existing responsibilities under their relevant code of conduct.

Health providers who are not registered under the 'National Registration and Accreditation Scheme' will need to apply to Comcare to be assessed and accredited on a national basis rather than as individuals. For example, the national body of masseurs (not subject to the National Registration

and Accreditation Scheme) will need to seek accreditation from Comcare rather than individual massage therapy providers.

Medical treatment costs totalling $37 million were incurred by injured employees of premium payers during 2012-13. Legally qualified medical practitioners provided 54 per cent of this treatment, 29 per cent was provided by allied health professionals and 17 per cent by other service providers such as masseurs etc. It is estimated that the practitioners providing 90 per cent of acupuncture, health and fitness and massage services, as well as 50 per cent of practitioners providing diet/nutrition, hypnotherapy and pain management services, may need to seek accreditation.



As a minimum, this would mean that practitioners who were paid 13 per cent of treatment costs ($4.8 million) during 2012/2013 will need to seek accreditation from Comcare.

Those health providers, for whom Comcare is required to independently assess the nature and standard of their qualifications and the treatments they provide, will experience an additional administrative burden during the accreditation process. However, this is a once-off activity and any burden will not be significant. This will be more than offset by reduced claim costs as injured employees benefit from evidence based treatment and therefore a more timely return-to-work.

Legally qualified medical practitioners nominated for the purpose of prescribing medications classified as drugs of addiction should not experience additional work as they are already required to monitor any prescription of drugs of addiction medications.

Any additional regulatory burden for health providers is justified in that it is part of ensuring best practice in treatment standards. Costs will be reduced over time as higher standards are met and injured employees return-to-work more quickly.

Impacts on Injured Employees

Amending the definition of 'medical treatment' will ensure that injured employees will receive evidence based, effective treatment which meets the standards established by the Clinical Framework by legally qualified health practitioners. This will result in an improvement in the health and return-to-work outcomes of injured employees, ensure that treatment standards are met and provide value for taxpayer money.

Employees will be required to ensure that medical treatment is obtained from legally qualified health practitioners or by health providers recognised and accredited by Comcare if the treatment is to be compensable.

In addition, employees will be required to nominate a legally qualified medical practitioner for the purpose of prescribing medications classified as drugs of addiction, if required.

6.3.2. Option Three - Cap on the lifetime costs of a claim, adoption of the National Clinical Framework, medical treatment to be provided by an Allied Health Provider or Comcare approved medical providers (based on WA model)

Impacts on Employer

Determining authorities, including licensees, will be required to ensure that medical treatment is provided by health practitioners who are accredited and registered under the 'National Registration and Accreditation Scheme' and in accordance with objective standards such as those in the Clinical Framework. Where treatment is provided outside the principles of the Clinical Framework, or where there are concerns about the adequacy, appropriateness or frequency of treatment, determining authorities will be able to refer practitioners to the appropriate professional regulatory bodies.

Determining authorities will only be liable to compensate injured employees for prescription medicines; however, they will continue to be exposed to risks of unlegislated boundaries around the funding of prescription medications. This may include injured employees doctor shopping, illegally selling or overusing medications, exacerbated injuries or even potential fatalities of employees.

Determining authorities will benefit from decreased medical costs through the use of a cap on lifetime medical costs. This figure will be indexed for inflation and can be reconsidered in cases where the whole person permanent impairment ratio is greater than 15 per cent, or if the worker's social or financial circumstances justify it, or both. This will reduce employer costs and give employers security regarding their workers' compensation liabilities.

Impacts on Health Providers

Health providers will be subject to the same impacts under both Options Two and Three: those who are registered under the National Registration and Accreditation Scheme will be able to continue to provide services to injured employees with a workers' compensation claim. Health providers who are not registered under the Scheme will need to apply to Comcare to be assessed and accredited (as a profession rather than as individuals).

Health providers seeking accreditation will experience an additional administrative burden during the accreditation process. However, this is a once-off activity and any burden will not be significant. Health providers that do not meet the criteria of evidence based medical treatment due to the nature and standard of their qualifications will likely face a reduction in their income.

In addition, the lifetime cap on claim costs will likely result in injured employees forgoing non-essential treatment which will have flow on effect to some health providers.

Impacts on Injured Employees

Limiting compensation to the services of medical providers registered under the National Registration and Accreditation Scheme, or accredited by Comcare, will ensure that injured employees receive evidence based, effective treatment which meets the standards established by

the Clinical Framework. This will result in an improvement in the health and return-to-work outcomes of injured employees, ensure that community standards are met and provide value for taxpayer money.

Employees will no longer have access to unlimited compensable medical treatment over the life of their claim and consequently may need to rationalise non-essential treatment.

6.4. Consultation

In response to the recommendations put forward by Mr Hanks in his review of the SRC Act, stakeholders provided the following comments.

The Australian Psychological Society commented:[28]

> 'The definition of therapeutic treatment (s 4) should be updated to ensure it is producing an outcome for employees. This will require a new clinical framework to be implemented addressing the issue of long term "maintenance" treatment within the scheme and also provide a nexus with "mental injury" (s 5A). The new framework will require an active partnership between the scheme, its providers and employers. The scheme should have access to a panel of expert clinicians reflective of its new bio-psycho-social focus, backed up with new guidelines on evidence-based clinical assessment and interventions. These expert clinicians have the responsibility to educate providers and employers on the new treatment framework and powers to direct providers to resubmit their treatment plans that do not comply. Employers on the other hand will be supported by expert clinicians who can assist them with early identification and intervention of claims (as well as prevention programs). Providers will be accessed in an appropriate and timely manner based on their training and qualifications and willingness to provide goal-oriented and evidence-based interventions.'

Comcare's submission to the Review noted that revising the definition of 'medical treatment' so that the effectiveness of the treatment could be measured:[29]

> '… would allow injured employees, their medical providers and determining authorities to assess whether the treatment is improving, worsening or not changing the effects of the compensable injury. This informs and justifies medical treatment decisions and prevents the development of dependence on ineffective treatment which may worsen the health outcomes of injured employees. Measurement of outcomes to determine clinical effectiveness is considered best practice. Measures should be related to the functional goals of treatment and relevant to the [injured employee's] injury.'

One of the medical experts consulted by the Review (who asked for anonymity) submitted[30]:

> 'Evidence indicates that compensation patients have a worse clinical outcome when matched for injury. Although not fully understood why, research indicates that a closer

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[28] Australian Psychological Society, Submission to the Review, pp. 3–4.

[29] Comcare, Submission to the Review, p. 33

[30] *Safety, Rehabilitation and Compensation Act Review Report*—February 2013, Peter Hanks QC, p. 128.

monitoring approach of treatment delivery by providers is required to drive best treatment outcomes in the compensation population.

One factor that is understood in the compensation patient cohort is the unique three way value transaction. The compensation client receives treatment and services, but makes no financial outlay and has reduced outcome leverage in the service provision. This results in a low financial risk for the patient and potentially reduces the tension over the cost benefit or cost effectiveness of treatment. The consequence is reduced accountability in the client – provider relationship for measurable health improvement and outcomes….'

6.5. Conclusion

The department recommends implementing Option Two on the basis that it introduces an evidence based, higher quality integrated framework for the provision and monitoring of medical treatment by appropriately qualified health practitioners, both in Australia and overseas. Option Two is anticipated to produce a significant improvement in treatment outcomes and reduce the cost of medical treatment under the SRC Act. Key benefits of Option Two are as follows:

- Ensuring all medical treatment is provided by legally qualified health practitioners or by health practitioners whose qualifications and experience have been accredited by Comcare.
- Ensuring that treatment provided adheres to the Clinical Framework and where is does not, enabling determining authorities to refer to the appropriate professional regulatory body to query the standard of the provided treatment.
- Providing that all medications compensated for under the SRC Act are recommended or prescribed medications only - and where they are classified as drugs of addiction in particular - they are prescribed only by a 'nominated legally qualified medical practitioner' to ensure their use is monitored.

This package of reforms was recommended by Mr Hanks in his 2012 review of the SRC Act.

The majority of those who responded to the Review agreed that if these recommendations were implemented there would be significant improvements in treatment outcomes.

The regulatory cost impact of these amendments is minimal for licensees and health providers. However, the improvement in treatment outcomes should produce savings in claims costs for licensees. The overall budgetary impact for the Government is nil.

7. Household and attendant care services — tiered system of services and support

7.1. The Problem

There is no clear framework in the SRC Act for the provision and monitoring of support services provided in the home (household and attendant care services), nor any means to ensure that those providing these services are appropriately qualified; in particular, attendant care service providers.

Under the SRC Act, household services are defined to mean services of a domestic nature (including cooking, house cleaning, laundry and gardening services) that are required for the proper running and maintenance of the injured employee's household. Attendant care services are services that are

required for the essential and regular personal care of an injured employee (other than household services, medical or surgical services or nursing care) and may include assistance with mobility, personal hygiene (bathing and toileting), grooming, dressing and feeding.

At present, the SRC Act provides insufficient mechanisms for the assessment and equitable provision of household and attendant care needs to injured employees.

In 2012-13, determining authorities paid $4.9 million for 1300 accepted claims for household and attendant care services. This is an increase of 34 per cent from 2008-09, when $3.2 million was paid by determining authorities for 900 accepted claims.

Compensation for support services provided in the home

Compensation for support services provided in the home is currently available to all injured employees, regardless of the nature or extent of the impairment sustained. There is also no limit on the period and total cost for which compensation for household and attendant care services is payable. This is imposing increased costs on employers and is not producing optimal outcomes for those most in need.

Attendant care services

In 2012-13, determining authorities paid $720,000 for attendant care services. This is an increase of 35 per cent from 2008-09.

Comcare data indicates that since 1989, of the 751 accepted claims for attendant care services, 70 per cent of claims were made within three years of the injured employees' date of injury; 25 per cent were made five or more years after the injured employees' date of injury; 13 per cent were made ten or more years after the injured employees' date of injury; and five per cent had been compensated for attendant care services twenty or more years after the injured employees' date of injury.

In addition, 23 per cent of injured employees did not make their first claim for attendant care services until after three years from the date of their injury.

Household services

There have been sustained increases in household services over the last five years. In 2012-13, determining authorities paid $4.2 million for household support services, compared to $2.7 million in 2008-09.

Comcare data indicates that since 1989, of the 5807 accepted claims for household services, 60 per cent of claims were made within three years of the injured employees' date of injury; 33 per cent were made five or more years after the injured employees' date of injury; 17 per cent were made ten or more years after the injured employees' date of injury; and four per cent had been compensated for household services twenty or more years after the injured employees' date of injury.

In addition, 19 per cent of injured employees did not make their first claim for household services until after three years from the date of their injury.

Providers of support services provided in the home

Currently the engagement of household or attendant care services is the prerogative of the injured employee. This limits any control on costs, the quality of the care and the development of formal care plans. There is no requirement for attendant carers to have any level of training to ensure the injured employee is receiving appropriate care. These issues can mean that an injured employee may not be correctly assisted to recover from their injuries or learn the coping strategies that they need to manage any residual impairment.

Determining authorities have a responsibility to protect the health and wellbeing of injured employees receiving compensation and to ensure appropriate usage of employer funds. However, the mechanisms provided by the SRC Act are insufficient to allow for the effective management and regulation of attendant care services funded under the SRC Act.

7.2. Options

7.2.1. Option One — Maintain the status quo

Maintaining the status quo will result in injured employees receiving compensation for unlimited support services provided in the home regardless of the nature or extent of the injuries sustained. Injured employees will continue to be responsible for the engagement (though costs are borne by determining authorities) of household or attendant care service providers. Combined, this cost determining authorities $4.9 million in 2012-13.

7.2.2. Option Two — Tiered system for support services provided in the home, formal framework for in-home services assessment, accreditation system for attendant care services

This option proposes a tiered system for the provision of support services provided in the home, as well as restricting long-term access to these services. Under this option, household services will be provided for three years from the date of injury. Attendant care services will be provided for three years from the date of injury and for an additional six months after specific events, such as the employee is admitted into hospital. An exception will be made in circumstances where an employee has sustained a severe (catastrophic) injury. Household and attendant care services will be provided on an ongoing basis for the severely injured with no cap on costs. A new definition of ‘catastrophic injury’ will be introduced into the SRC Act to accommodate this provision.

Under this option, Comcare will establish a formal framework for the assessment of need for support services provided in the home. Any need for these services will be assessed by an independent party such as a registered occupational therapist.

Comcare will also be empowered to prepare and issue a list of approved attendant care providers recognised under the SRC Act. Other entities such as the Department of Veterans’ Affairs have already established lists for ex-service men and women that could be used as the basis for the Comcare list.

There are situations in which it may be appropriate for a family member to provide attendant care services. In these situations, the family member should be registered with an attendant care provider and required to meet all qualifying requirements.

This issue was considered by Mr Hanks in his 2012 review of the SRC Act and this option is consistent with recommendations from that review.

7.2.3. Option Three - Household and attendant care services provided at the request of a medical practitioner and with the support of an occupational therapist, for a maximum of 6 hours per week and for not longer than three months. Attendant care services must be provided by a person or organisation approved by Comcare and an 'attendant care program' must be developed.

This option is a hybrid of the household and attendant care services provided in New South Wales and Victoria. In order to be compensable, household and attendant care services must be requested by a medical practitioner and supported by an occupational therapist after completing an in-home assessment of the injured worker.

Attendant care must be provided by a person or organisation certified by Comcare as an approved attendant care provider. Paid attendant care services cannot be provided by friends or family members unless under exceptional circumstances.

An attendant care program must be developed for each injured employee specifying the goals of the program; description of the care and services to be provided; specific duties of the attendant carer; other support services to be involved; hours recommended; regular review intervals; and program duration.

Household and attendant care services will be provided on a temporary basis for not more than 6 hours per week and for a period that is not longer than, or during periods that together are not longer than 3 months.

7.3. Impact Analysis

The impact analysis considers the impact of the changes beyond the status quo.

7.3.1. Option Two — Tiered system for support services provided in the home, formal framework for in-home services assessment, accreditation system for attendant care services

By introducing a tiered model for the provision of support services provided in the home and a formal framework to assess the need for services, the integrity of the SRC Act is improved and funding is utilised where it is most needed. Payments to the less injured are carefully controlled, while payments to the severely injured may be increased to provide better support.

Impacts on Attendant Care Providers

This option should not place a regulatory burden on attendant care providers as Comcare could use an already established list of approved attendant care providers. If an established list is not utilised, attendant care providers will be required to produce documents and show evidence of experience in order to provide services under the SRC Act. This would result in a medium regulatory burden.

Impacts on Employers

This option will impose an additional compliance burden on determining authorities, which will be more than offset by the resulting fall in claim costs.

Impacts on injured employees

Comcare data indicates that 19 per cent of injured employees did not make their first claim for household services until after three years from the date of their injury; and 23 per cent of injured employees did not make their first claim for attendant care services until after three years from the date of their injury. Under this option, injured employees who do not have a severe injury will not be able to claim household services or attendant care services after three years from the date of their injury, unless they claim attendant care services as a result of a specific event.

Limiting compensation for household and attendant care services to a maximum period of three years (and attendant care to a maximum of six months following a specific event) should provide sufficient time for employees to recover from most injuries, be rehabilitated for return to the workforce and learn any coping strategies that they need to manage any residual impairment.

Payments for attendant care services for employees with catastrophic injuries will be uncapped under this option, from a maximum weekly rate of $442.40 (as at 1 July 2014), thus providing better support where required.

Injured employees will not be able to continue to receive compensation for attendant care services if those services are provided by family members not recognised by Comcare as approved providers. This may limit injured employees choice in regards to selecting providers of those services.

7.3.1. Option Three - Household and attendant care services provided at the request of a medical practitioner and with the support of an occupational therapist, for a maximum of 6 hours per week and for not longer than three months. Attendant care services must be provided by a person or organisation approved by Comcare and an 'attendant care program' must be developed.

Impacts on Attendant Care Providers

As with Option two, this option should not place a regulatory burden on attendant care providers as Comcare could use an already established list of approved attendant care providers. If an established list is not utilised, attendant care providers will be required to produce documents and show evidence of experience specified by Comcare in order to provide services under the SRC Act. This would result in a medium regulatory burden.

Impacts on Employers

This option will impose a sightly additional compliance burden on determining authorities to monitor the use of household and attendant care services. However, this will be more than offset by the resulting fall in claim costs.

Impacts on injured employees

This option may be administratively burdensome to employees, as they will be required to prove that they are entitled to household and attendant care services.

Limiting compensation for household and attendant care services to a maximum period of three months may significantly reduce the time available for injured employees to recover from their injuries.

Injured employees will receive better targeted and effective services as a result of the 'attendant care program'. They will also benefit from programs delivered by qualified professionals who are trained to teach them long-term coping mechanisms.

Injured employees will not continue to receive compensation for ongoing attendant care services if those services are provided by family members not recognised by Comcare as approved providers. This may limit injured employees choice in regards to selecting providers of those services.

7.4. Consultation

In response to the recommendations put forward by Mr Hanks in his 2012 review of the SRC Act, stakeholders provided the following comments:

> The previous Department of Finance and Deregulation supported all recommendations for household and attendant care services. However, it believed that an independent medical (panel) assessment should be conducted where the severe injury falls into the category of 'other injury' and includes a secondary psychological condition[31].
>
> Telstra supported the implementation of a tiered system of household and attendant care services and support. However, it advised that compensation for household and attendant care services for the severely injured should be subject to ongoing reviews, particularly for the severely injured. Telstra supported the establishment of a formal framework for the assessment of need for household and attendant care services but believed that physiotherapists should only be required to complete this assessment in limited circumstances[32].
>
> Assessments Australia strongly agreed with the Review recommendations in relation to a framework for assessment of need for services provided in the home and that any need is assessed by an independent third party[33].
>
> Australia Post agreed with the recommendations with a clarification that household services are payable for 'up to' three years. This would avoid an expectation that household services would be paid beyond when they are required[34].
>
> The Australian Council of Trade Unions did not support the introduction of the new term 'severe injury' as it believed 'injury' is currently sufficiently defined[35].
>
> The Australian Manufacturing Workers' Union supported a three-tiered approach for home services. However, it did not believe this should be time-limited. It opposes the proposed definition of 'severe injury 'as too narrow and opposes capping of household care and attendant services at 40 hours per week at a cost of $1700[36].

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[31] The Department of Finance and Deregulation, Submission to the Review, pp. 7–8.

[32] Telstra, Submission to the Review, pp. 14–15.

[33] Assessments Australia, Submission to the Review, pp. 2.

[34] Australia Post, Submission to the Review, pp. 4.

[35] Australian Council of Trade Unions, Submission to the Review, pp. 11.

[36] Australian Manufacturing Workers' Union, Submission to the Review, pp. 9 and 12.

The Australian Lawyers Alliance believed some discretion should be allowed, in appropriate cases, to exceed the maximum 40 hours per week for attendant care services[37].

The Law Council of Australia agreed that it is reasonable for household services and attendant care to be reviewed periodically and more critical scrutiny placed on its provision, but did not support the recommendations. Specifically, it believed that the definition proposed for 'severe injury' is too restrictive and does not, for example, include psychological injuries. The test to determine the severity of the injury does not take into account the injury circumstances of the employee; the amount of non-paid, family assistance that may be available to them; and the cut- off point of three years for household and post-acute service seems arbitrary and without merit. The Law Council of Australia believed the problem has been the lack of regular review of these services rather than the model of delivery itself[38].

7.5. Conclusion

Option Two is the recommended option for the provision of support services under the SRC Act. This option will ensure that services are targeted at those injured employees most in need and provided at the time the services are most needed. This option also ensures that support services are provided by appropriately qualified persons. For those who suffer a temporary impairment, services are provided only as needed, while those with more severe injuries and impairments are able to access increased and ongoing support.

The increased regulatory impact on attendant care providers and determining authorities is outweighed by more equitable, effective, transparent, evidence-based and targeted provision of services and the savings in claims costs.

Option Two will ensure more cost effective provision of support services and ensure improved care and service standards.

8. Medical treatment and legal costs

8.1. The Problem

The department, in reviewing the costs and operation of the SRC Act, has identified the potential for better operational efficiency and consistency in the areas of medical service fees, medical report costs and legal costs arising from disputation.

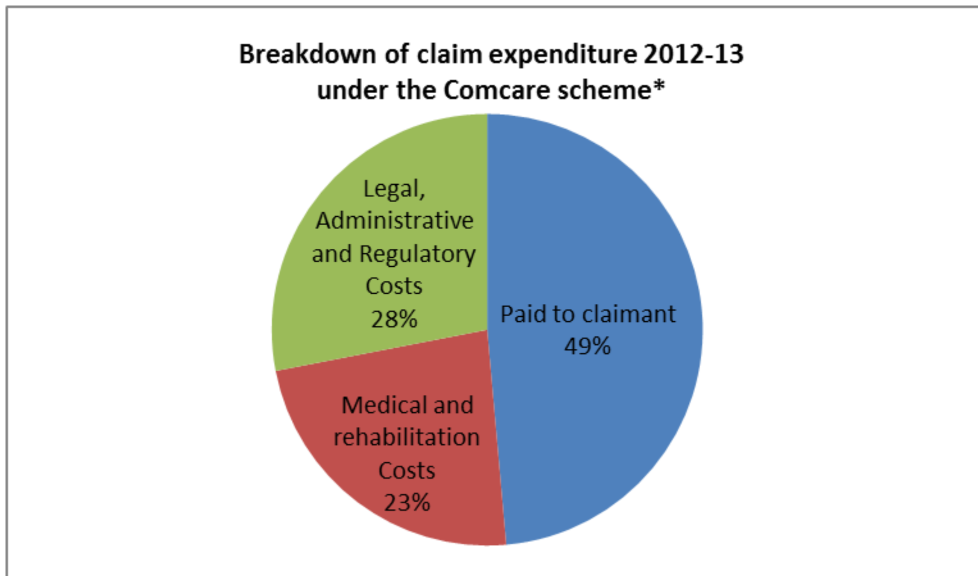
Comcare has a responsibility to ensure that health and legal practitioners are held accountable for their conduct and do not take advantage of the SRC Act, or injured employees, by over-charging, over-servicing or providing services that do not meet basic professional standards. Comcare's current inability to exert any form of regulatory oversight over the cost of medical and legal services affects the financial integrity of the SRC Act's workers' compensation scheme. Additionally the party

[37] Australian Lawyers Alliance, Submission to the Review, pp. 7.

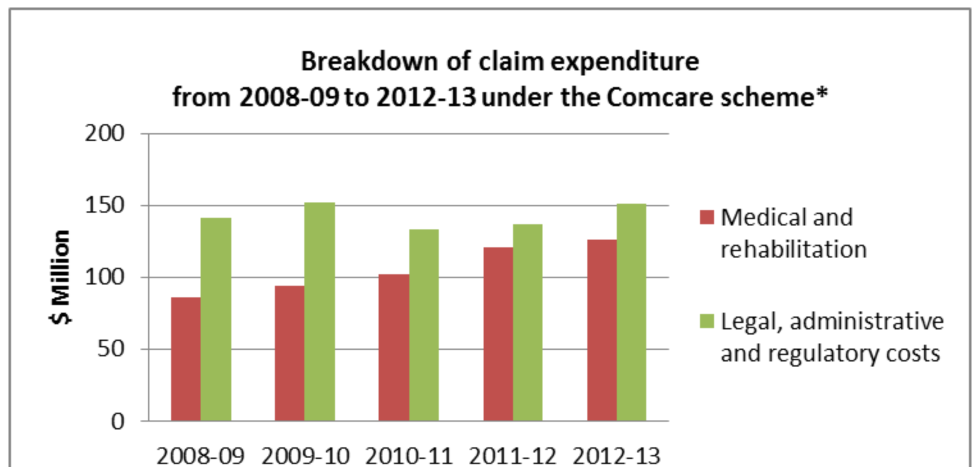
[38] Law Council of Australia, Submission to the Review, pp. 9.

that receives the services does not bear the cost which creates the potential for over-servicing (a 'principle-agent problem').

Workers' compensation schemes in other jurisdictions control medical and legal costs. The lack of regulation of medical and legal costs under the SRC Act makes it vulnerable to providers willing to take advantage of the fact that they will be reimbursed for whatever services and fees they see fit to impose.



[39]



[40]

*This refers to costs of both premium payers and licensees.

Medical Treatment Costs

Medical and rehabilitation costs currently represent 23.4 per cent of the total costs of claims liabilities under the SRC Act. This figure has been increasing at a consistent rate over the past three years. The SRC Act currently allows for compensation of medical treatment costs 'of such amount as Comcare determines is appropriate for that medical treatment'. In practice, Comcare has limited

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[39] Data provided by Comcare on claim expenditure for 2012-13

[40] Data provided by Comcare on claim expenditure from 2008-09 to 2012-13

ability to determine the 'reasonableness' or the 'appropriateness' of the treatment. Comcare is not permitted, under the SRC Act, to have any involvement in, or control over, an injured employee's choice of medical or therapeutic practitioner or treatment. Medical costs are approved on a case-by-case basis, with appeals to the Administrative Appeals Tribunal (AAT) further varying the amounts paid. In some cases, this creates inequitable outcomes.

Medical Report Costs

One of the most immediate and pertinent increases in medical costs relate to the provision of medical reports by legally qualified medical practitioners. A workers' compensation medical report will generally relate to events or injuries that occur in relation to causation, capacity for work, or treatment or assessment of permanent impairment. These reports provide detailed information about an injured employee's condition and are not only used to determine liability, but may also be requested to assist decision-making at any stage of the claims process where existing information is inadequate.

In 2012-13, medical reports cost $6.8 million; an increase of 22.1 per cent since 2008-09. In addition, the cost of medical reports not resulting from section 57 medical examinations[41] was $3.7 million; an increase of 43.2 per cent since 2008-09. The issue, in this instance, is not that medical reports are considered surplus, but that the cost of medical reports does not accurately reflect the required reporting complexity. A standard report will involve assessment of a single event or injury, or a simple permanent impairment assessment. A complex report requires more complex methods of permanent impairment assessment, including assessment of multiple injuries. In instances where the report is being prepared a by an independent medical professional, the need to examine the employee and consider documentation from other sources will contribute to the cost.

Currently, there is nothing to prevent a practitioner producing an overly complex report where a standard report is required, or a standard report where a more complex report is needed. The determining authority is then obliged to pay for either sub-standard or over-priced reports, depending on the complexity of the injury.

Legal Costs

Following an initial determination of a claim, either party to the claim may apply for an internal 'reconsideration' by the determining authority. Up to this point, legal representation is not envisaged and therefore not payable by the determining authority. If either party disagrees with the reconsideration, they can have the matter reviewed externally by the AAT. Matters may then be progressed to the Federal Court of Australia or the Federal Magistrates Court on questions of law only.

Determining authorities are liable for their own legal costs in all matters brought before a court or tribunal; in addition, if the matter is found in favour of the employee, the determining authority is also liable for the employee's legal costs.

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[41] Under section 57 of the SRC Act, a determining authority is able to require an injured employee to undergo an examination by a legally qualified medical practitioner nominated by the determining authority.

In the last year alone, legal, administrative and regulatory costs paid under the SRC Act have increased by 11 per cent. Legal costs are directly correlated to dispute resolution timeframes and disputes under the SRC Act have, at 44.8 per cent, the lowest resolution rate - for disputes resolved within nine months - of all Australian workers' compensation schemes. The more protracted a matter in the AAT, the greater the legal costs. By comparison, New South Wales resolves 97.3 per cent of disputes within nine months. In the last financial year, reconsiderations under the SRC Act have increased five per cent, with a four per cent decline in the number of matters proceeding to the AAT. The corresponding and disproportionate 11 per cent increase in scheme legal costs underscores the fact that the current protracted dispute resolution timeframes under the SRC Act are highly undesirable.

There is limited provision under the SRC Act by which to curtail payment of excessive legal costs arising from disputation of claim decisions. Once a case has proceeded to the AAT, the Tribunal cannot order an employee to pay the respondent's costs; that is, the costs incurred by Comcare, licensees or DVA. In practice, and in the current legal climate of 'no win no pay', there is little to discourage the employee progressing a claim to the AAT when they are not required to meet the respondent's costs. This is not the case for the respondent who is required to meet the employee's costs, no matter how trivial the issue or how unnecessarily protracted the proceedings.

Taxation of legal costs is the only strategy currently available under the SRC Act to recover legal costs. Taxation of legal costs refers to the process by which a court may fix the amount of costs it orders one party to pay to the other. Alternatively, a taxing officer may assess the amount of costs by reference to the relevant scale of costs. Taxation is generally designed to regulate the level of legal costs and shield participants from excessive charging. However, parties are generally reluctant to proceed to taxation as it incurs a cost in itself and is typically seen only as a tool for managing costs in extreme circumstances.

In limited circumstances, determining authorities can also employ Calderbank offers. A Calderbank offer refers to the process by which an employee refuses a pre-trial offer, proceeds to trial and then receives a trial offer that is not more favourable than the terms of the original offer. In this case, the determining authority can then apply to the AAT to exercise its discretion not to award all or parts of the costs to the injured employee. However, because the AAT cannot order an employee to pay a respondent's costs, Calderbank offers have only a limited impact on workers' compensation cases, particularly as relevant authorities must still pay their own costs, regardless of whether or not the matter may have settled pre-trial.

8.2. Options

8.2.1. Option One — Maintain the status quo

Medical service fees and medical report costs

Retaining the status quo will result in the continuation of existing problems identified by Mr Hanks and annual Comcare financial reports. These include rising medical compensation costs, provision of inconsistent medical treatment for injured employees and financial unsustainability of workers' compensation under the SRC Act in the long-term. Determining authorities will continue to lack any enforceable instrument that will permit effective regulation of medical compensation costs and services. As such, they will continue to be liable for medical treatment costs that result from treatment prescribed without regard to consistency, suitability and the financial sustainability of a

workers' compensation body. Given that medical compensation costs under the SRC Act have increased considerably over the last three years, there is little doubt that retention of the status quo will see similar, if not greater, increases in medical compensation costs and related problems in the coming years.

Legal Costs

Under this option, determining authorities will continue to pay inflated legal costs without the means to moderate them or to discourage protracted disputation.

8.2.2. Option Two — Develop a schedule of costs for medical services, medical reports and legal services

Medical service fees and medical report costs

Under this option, the SRC Act will be amended to allow Comcare to develop a Schedule of Medical Service Fees. This list of regulated fees will be used to pay medical practitioners and suppliers for medical and rehabilitation services under the SRC Act. These fees will be set by Comcare, in consultation with relevant professional associations, and will have legislative authority as the rates at which determining authorities are liable to pay compensation for medical treatment under the SRC Act. This amendment was recommended by Mr Hanks.

Pricing levels for medical reports will also be set by Comcare and will have legislative authority as the rates at which determining authorities are liable to pay for medical reports under the SRC Act.

Legal costs

Under this option, the SRC Act will be amended to enable the development and enforcement of a Schedule of Legal Costs, similar to those that apply in the states and territories. This will be a list of legal services that are compensated on the basis of time (Western Australia) or cost (New South Wales), or a combination of both. The schedule will provide guidance for determining authorities, injured employees, employers and legal representatives as to what constitutes reasonable amounts of time and/or expenditure on prescribed workers' compensation issues. The schedule of legal costs will have legislative authority as the rates at which determining authorities are liable to pay for legal costs under the SRC Act.

Legal Cost Schedule Examples – New South Wales & Western Australia

	Costs model – example NSW	**Amounts Payable**	**Hours model – example WA**	**Maximum Allowable Hours**
Item	Lump sum compensation claim or dispute resolved before application accepted by Registrar	Claimant $2475 - $3275 Insurer $1575	Obtaining instructions from client and attempts to resolve the dispute by negotiation prior to involvement in a proceeding	4
Item	Other compensation dispute resolved – after initial teleconference up to and including conciliation conference including consequential settlement attendances.	Claimant $4250 - $5645 Insurer $3665 - $4860	Where the dispute is resolved at or after an arbitration hearing, including all necessary preparation and documentation in the approved form in accordance with the Arbitration Rules. Add for each additional hearing.	+7 +7

8.2.3. Option Three — Utilise state medical services and medical report schedules where they exist and refer appeals to mediation and advocacy services

Medical service fees and medical report costs

Comcare will use the relevant state or territory medical fee and medical report schedules, where they exist, to reimburse medical expenses in the state or territory in which they were incurred. New South Wales, Victoria, Queensland, Western Australia and South Australia currently have fees schedules which could be utilised. These could also be applied to the remaining jurisdictions (Tasmania, Northern Territory and the Australian Capital Territory) based on a combination of proximity and similar economies. For example, Western Australia's cost schedules could be applied to the Northern Territory as they both have similar cost pressures of remoteness; and South Australia's cost schedules could be applied to Tasmania and the ACT as they have similar cost pressures of a relatively small economy.

Legal Costs

Comcare will establish an alternative dispute resolution service, in the form of mediation or an advocacy service, that could be accessed following a reconsideration and as an alternative to legal proceedings through the AAT. If mediation or advocacy was unsuccessful, the claim would proceed to the AAT on appeal.

8.3. Impact Analysis

This impact analysis considers the impact of the changes beyond the status quo.

8.3.1. Option Two — Develop a schedule of costs for medical services, medical reports and legal services

Medical Service Fees and Medical Report Costs

The implementation of a structured pricing approach to the provision of medical compensation services under the SRC Act will ensure accountability for tax payer and employer costs and be an important legislative recognition of Comcare's right to more effectively manage medical costs and pursue more sustainable financial outcomes. The regulation of medical report costs will ensure medical reports more accurately reflect the complexity of an employee's injury.

This option is consistent with the approach in state and territory workers' compensation jurisdictions and creates certainty for both providers and employees as to what medical compensation amounts will be paid under the SRC Act.

Impacts on Employers

Under this option, there will be a decrease in the time and compensation costs associated with disputation of medical compensation payments and unnecessary or excessive medical reporting. This option will also provide a disincentive to over-charging and over-servicing of injured employees.

There will be associated establishment and enforcement costs for Comcare to prepare and issue a table of medical service rates. This amendment may also result in minor changes to the regulatory burden for determining authorities, as they will need to crosscheck payments against the medical service rates. However, as this option will be implemented in tandem with schedules of medical service fees and legal costs, it will avoid duplication of consultation, implementation and

administrative costs. It will also result in improved administrative processes through consistent reporting and defined standards.

Impacts on Injured Employees

Injured employees will retain the right to a treating practitioner of their choice. However, where treatment costs are in excess of the prescribed schedule, these costs will no longer be borne by the determining authority. In practice, employees may be less likely to retain treating practitioners whose costs are above the pricing schedule in order to minimise their own out of pocket expenses.

Firmer guidelines for medical reports will allow for a standard of consistency and accuracy that will enable more effective investment in an injured employee's treatment, recovery and rehabilitation.

This amendment, implemented in isolation, may be seen by employees as a reduction in benefits under the scheme. However, the package of proposed reforms will improve the delivery of medical services and outcomes under the SRC Act. The adoption of clinical justification principles (in the Clinical Framework) will ensure that treatment is reasonable, transparent and cost effective, and highlights the need for the provider to deliver value (or a functional outcome) to the injured worker. In addition, research also indicates that when treatment is provided by experts in compensation care and in an environment of high accountability, health outcomes for compensation patients are vastly improved[42].

Impact on Health Providers

Practitioners have the legal right to charge in excess of schedule rates, regardless of whether the rates are prescribed by workers' compensation bodies or the Australian Medical Association (AMA). This reflects general medical practice and is not limited to patients presenting with work-related conditions.

The department has consulted with health practitioners in regard to scheduling medical treatment costs. While there is general support for costs schedules, this support is predicated on the assumption that costs schedules reflect market pricing.

Legal Costs

Several state and territory jurisdictions have legislated legal costs, fixing maximum costs or number of hours, for legal services provided in connection with workers' compensation matters. The main objective of having a schedule of legal costs is to ensure that legal costs are proportionate to the importance and complexity of the subject matter in dispute.

Impacts on Employers

There will be cost implications for the development of a legal costs schedule. However, legal costs schedules have precedent in other Australian workers' compensation schemes and it is expected these schedules will be referenced in order to mitigate initial implementation costs.

Additional administrative and resource costs are likely for a transitional period as determining authorities and the AAT adopt and adapt their systems to legislative change.

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[42] Safety, Rehabilitation and Compensation Act Review Report 2013, Peter Hanks QC, p 141

Medium-term post-implementation costs would include regular review of the fees prescribed in the schedule by Comcare to ensure currency. These would be borne by premium payers and licensees through regulatory costs paid to Comcare.

Impacts on Injured Employees

In workers' compensation matters, the personal nature of the subject matter can sometimes lead to excessive time and money being spent on relatively unimportant or simple legal issues. A formalised schedule of legal costs will limit the potential for over-charging and over-servicing and may reduce the incentive for individuals and their lawyers to litigate weak and unlikely claims.

Introducing a schedule of fees would not limit an employee's right to pursue legal action but it would limit determining authorities' financial liability for such actions.

A schedule of fees would set parameters as to compensable costs for all parties to a dispute, providing certainty about what would and would not be paid. In turn, placing limits on legal costs would provide further incentive to resolve disputes in a timely manner.

8.3.2. Option Three — Utilise state medical services and medical report schedules where they exist and refer appeals to mediation and advocacy services

Medical service fees and medical report costs

The main benefit of using state service fee schedules is that Comcare would avoid the costs associated with establishing its own schedule. State schedules would also be more closely aligned to the living costs and standards of each state and avoid the standardisation of medical costs that must arise from a national fee schedule.

Impacts on Employers

The use of established fee schedules could possibly minimise implementation costs. However, this option does not offer national consistency and multiple fee schedules would be administratively inefficient, with claims staff required to reference and check payments against multiple state schedules and payment systems.

Impacts on Injured Employees

Injured employees will retain the right to a treating practitioner of their choice. However, where treatment costs are in excess of the prescribed schedule, these costs will no longer be borne by the determining authority. In practice, employees may be less likely to retain treating practitioners whose costs are above the pricing schedule in order to minimise their own out of pocket expenses.

This amendment, implemented in isolation, may be seen by employees as a reduction in benefits under the scheme. In addition, varying levels of reimbursement between jurisdictions for employees employed by the same organisation may be perceived as unfair.

Impact on Health Providers

Practitioners have the legal right to charge in excess of schedule rates, regardless of whether the rates are prescribed by workers' compensation bodies or the AMA. This reflects general medical practice and is not limited to patients presenting with work-related conditions.

Health practitioners would also be familiar with compensation amounts and would require little adjustment to pricing under the SRC Act.

Legal Costs

Impacts on Employers

An effective alternative dispute resolution service could positively influence disputation rates and lower associated legal costs. The provision of a less adversarial approach to dispute resolution could be sufficient to avoid progression of many disputes to the AAT and avoid the resulting legal costs.

There would be establishment and ongoing resourcing and maintenance costs for a mediation service. If the service is offered as a free service to disputing parties, it would require access to funding - either from government appropriations or from premiums and regulatory contributions - which may prove prohibitive for a comparatively small workers' compensation scheme.

Impacts on injured employees

An unsuccessful mediation would add another layer to the dispute resolution process, impose additional costs and increase the time taken to resolve disputes.

8.4. Consultation

In response to the recommendations put forward by Mr Hanks in his 2012 review of the SRC Act, stakeholders were generally supportive of setting medical service rates.

Capping medical report or legal report costs was not considered by Mr Hanks in his review of the SRC Act. However, the *Safety, Rehabilitation and Compensation Licensees Association* (SRCLA) first raised the issue of medical report costs noting that there is strong support amongst self-insurers and premium payers for this amendment.

During the most recent consultation process, health practitioners noted that AMA's list of fees could be used to guide the Comcare's fee schedule. However, the list should not be published on Comcare's website as this would reduce AMA's commercial interests. It was also noted that 'you get what you pay for'; for example, there are currently only two neurosurgeons in South Australia who accept the rate paid by WorkCover. There was also concern as to how the rates would reflect qualifications; for example, in New South Wales, payment rates are linked to course completion rather than the level of qualification of the health professional.

Licensees strongly supported the introduction of a fee schedule for medical costs, particularly medical report costs. However, it was suggested that the legal fee schedule should not apply to licensees.

Legal practitioners indicated they were not prepared to reduce their fees, which they said would result in injured employees paying the gap, forgoing the service or 'bottom feeders' entering the market.

Recent departmental consultations with the Australian Public Service Commission, the Department of Veterans' Affairs and Comcare indicate there is support for this amendment.

8.5. Conclusion

In compensation matters, the insurer, as the third party payer, takes on a greater accountability for outcomes by the provider as it manages the financial transaction. Contemporary compensation legislation needs to take into account the financial risks of treatments and the subsequent impact on scheme viability.

The use of fee schedules to regulate workers' compensation medical treatment costs is current practice for some state and territory jurisdictions. In addition, the AMA also prescribes suggested rates for health practitioners.

The department recommends Option Two, the introduction of Schedules of Costs for medical service fees, medical report costs and legal costs developed by Comcare. The regulation of medical and legal costs would give Comcare the authority to implement measures necessary to ensure the long-term financial sustainability of workers' compensation under the SRC Act, reduce overall disputation rates and improve certainty, for all parties, as to the SRC Act's compensatory limits. A national legislated Schedule of Costs under the SRC Act would reduce the regulatory burden for employers and prevent perceived inequity between jurisdictions.

9. Costing

The Office of Best Practice Regulation requires the calculation of costs associated with the regulatory burden of each option to be tabled in a Regulation Impact Statement (RIS). However, the regulatory costs of all options provided in this RIS relate mostly to updating IT systems and training staff on new methodology. As these costs relate to the fact there is a change rather than the quantum of the change, the regulatory burden is the same across all options.

Most claim management functions are completed with the use of specialised software and any significant changes to claims management processes, such as those that are analysed in this RIS, will require a re-design of system software. There are five IT companies - SBC, Figtree, SAP Cnet, Marsh CS Stars and SAI Global/Cintellate - who provide IT systems to all licensees. Therefore, the cost of updating IT systems will be limited to these companies only.

Claims management staff will also require training on new systems. There are currently 17 organisations that perform claims management services for the 33 licensees. This is because:

- two insurance companies share eight licensees' contracts for claims management and training for those companies will apply to all their licensees in their contract (i.e. the training will not be for each licensee but for each insurance company's claims managers).
- four corporate groups provide claims management for 11 licensees (five with Commonwealth Bank, two with National Bank, three with John Holland and one with Gallagher Bassett) and would only require one set of training per corporate group.
- the remaining 11 licensees do their own claims management in-house.

IT and training costs have been applied to current licensees only as costs for new licensees entering the scheme after the introduction of these amendments are considered to be establishment costs.

Where regulatory costs go beyond updating IT systems and training staff on new methodology - for example, accreditation costs for attendant care providers and health practitioners not registered under the 'National Registration and Accreditation Scheme' - they are a feature of both options and, therefore, they do not change regulatory costs between options. Accreditation costs for attendant care providers include undertaking a course with a tertiary institution, while health practitioners' costs are associated with the time it takes to complete application requirements.

Taylor Fry Actuaries conducted costings on the proposed package of changes in July 2014. As a result of the improved return-to-work outcomes as well as changes to the benefit structure, the Government's package of changes will save both premium payers and licensees between 12 per cent

and 21 per cent annually. This equates to between $62 million and $105 million for premium payers and between $19 million and $32 million for licensees.

9.1. Regulatory Burden and Cost Offset Estimate Table

Average Annual Regulatory Costs (from business as usual)

Change in costs ($million)	Business	Community Organisations	Individuals	Total change in cost
Income replacement	$0.037			$0.037
Evidence based medical treatment	$0.024			$0.024
Household and attendant care services	$0.027			$0.027
Accreditation of attendant care providers			$0.010	$0.010
Medical treatment and legal costs	$0.014			$0.014
Other changes in submission	- $0.256			- $0.256
Total by Sector	- $0.154		$0.010	- $0.144

Are all new costs offset?

☐yes, costs are offset ☐ no, costs are not offset ☑ deregulatory, no offsets required

Total (Change in costs - Cost offset) ($million) -$0.144

10. Stakeholder Consultation

The department considers that the issues raised in this RIS have been discussed, reviewed and consulted on extensively over the last two years.

An early assessment RIS was initially prepared and submitted to Cabinet for its consideration of the proposed policy. It was not considered necessary to publish a RIS for consultation due to the detailed and lengthy consultation that occurred from 2012 to 2015. The RIS was finalised and published upon the introduction of the Safety, Rehabilitation and Compensation Amendments (Improving the Comcare Scheme) Bill 2015.

10.1. Engagement Methods

The department has engaged in extensive and ongoing consultation with participants in the Scheme to:

- inform the content of the SRC Act Review and its recommendations;
- gauge stakeholder responses to the SRC Act Review recommendations; and
- inform the second stage of the proposed reforms to the SRC Act.

Engagement methods included:

- targeted consultation groups
- meetings
- public submissions tenders
- workshops
- cross agency working groups

10.2. Consultation Process

The Department of Employment conducted the following stakeholder consultation sessions between July 2012 and June 2014.

10.2.1. Consultation Stage 1

The review of the SRC Act in 2012-13 was a broad review that looked at a range of legislative and operational areas, including scheme governance, performance and access to self-insurance.

Consultation was conducted in three stages by Mr Peter Hanks QC and Dr Allan Hawke AC and consisted of:

1. initial meetings with targeted participants to develop a preliminary list of issues and possible recommendations;
2. publication of an issues paper to stimulate and encourage public submissions to the review;
3. focus workshops with select participants and participant groups to explore particular issues and matters arising in the submissions; and
4. acceptance of written submissions.

Approximately 44 workshops, meetings and other consultations were held between July and November 2012. Written submissions for the Issues Paper closed on 25 October 2012 and 45 submissions were received.

10.2.2. Consultation Stage 2

On publication of the SRC Act Review report in March 2013, a series of consultations were conducted in April 2013 with key stakeholder groups in Canberra, Sydney and Melbourne. The purpose of the consultations was to gauge stakeholder response to the SRC Act Review and to inform future implementation of the recommendations.

The consultations included feedback sessions held by the department and written submissions regarding the recommendations in the final report. Forty written submissions were received by the department during April and May 2013. Stakeholders who made submissions and participated in workshops and consultations included workers, employer organisations, unions, insurers, Comcare, Commonwealth government agencies, current licensees, premium payers under the scheme, health practitioner bodies and legal practitioners.

10.2.3. Consultation Stage 3

The purpose of the consultations was to inform the second stage of proposed reforms to the SRC Act and advise stakeholder groups of the proposed content of the SRC Act reform package.

A series of confidential consultations were conducted with key stakeholder groups in Canberra, Sydney and Melbourne during May to June 2014.

Details regarding the stakeholders involved in the consultations are detailed in the table below.

Key Stakeholder Group	Number of consultation sessions	Number of Stakeholders
Unions	2	10
Licensees	3	18
Legal Practitioners	2	11
Rehabilitation Providers	1	5
Health Service Providers	1	9
Commonwealth Agencies *Including Comcare, Military and Rehabilitation Compensation Commission, Department of Veteran Affairs*	6	14
ACT Government	1	1
Total	16	68

Confidential consultations were conducted to assist in the development of the Government's response to the Review's recommendations and the proposed reforms not addressed by the Review. Participants were also invited to submit written responses to the recommendations.

10.2.4. Other Consultation – Cross Agency Working Groups

The purpose of the consultations was to inform the second stage of proposed reforms to the SRC Act and stimulate policy discussion.

During December 2013 to May 2014, representatives from Australian Government Agencies, Comcare and the Department of Veteran's Affairs were invited to attend a series of workshops

conducted in Canberra. Meetings were held on a fortnightly basis to present research on issues pertinent to the recommendations. Participants were encouraged to provide comment or written feedback, including presentation of their own research.

The following Australian Government Agencies were represented at the working group meetings:

- Department of the Prime Minister and Cabinet
- Australian Public Service Commission
- Department of Finance
- Treasury

10.2.5. Committee on Industrial Legislation

The purpose of this consultation was to identify any unintended consequences in the Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015.

The Committee on Industrial Legislation (CoIL) is a subcommittee of the National Workplace Relations Consultative Council and meets when required to provide technical input on draft workplace relations legislation. It is common practice to convene the CoIL to consider workplace relations and work health and safety legislation.

A CoIL like process was held in Canberra on 19 February 2015 where representatives from employer and employee peak bodies were provided with a draft of the Bill in confidence to review and provide feedback.

10.3. Consultation Feedback

Stakeholder groups, despite varying motivations, have generally been supportive of many of the proposed amendments, recognising the need to modernise a piece of legislation that has remained largely unchanged since its introduction in 1988.

A summary of the feedback received from various stakeholder groups is outlined below.

10.3.1. Licensees and Premium Payers

Both groups are supportive of amendments that streamline operational procedures and reduce upward pressure on premiums and claims costs, in particular proposed step-down arrangements which will provide organisations with a tool to better manage claims.

10.3.2. Industry Groups

Legal Practitioners:

Legal Practitioners have mixed opinions of the recommendations, but are generally supportive of amendments that seek to clarify difficult or controversial case law. They are concerned about recommendations that they perceive as tightening eligibility requirements, particularly for mental stress claims, as well as the potential reduction in benefits for injured employees.

Health Practitioners:

Health practitioners are generally supportive of amendments that improve the health and return-to-work outcomes of injured workers. They require that any intended medical costs schedules accurately reflect market costs.

Rehabilitation Providers:

Rehabilitation Providers have been supportive of the rehabilitation amendments and the reform package's emphasis on improving return-to-work outcomes, including compliance measures.

Trade Unions and Employees:

Trade unions recognise the benefits of improving return-to-work arrangements for injured employees. However they are not supportive of any amendments that they perceive as reducing monetary compensation or access to the broadest range of rehabilitation support services.

10.4. Ongoing consultations

Ongoing consultation with Comcare, the Department of Veteran Affairs, Australian Public Service departments, licensees and other determining authorities will continue during implementation of the operational requirements of the proposed reforms.

11. Implementation and Evaluation

The Government will introduce a Bill to legislate the amendments in early 2015. The department will monitor the impact of these legislative changes on employers and employees to ensure they meet their intended objectives. A key aspect of this monitoring will be whether the amendments reduce claim costs for employers and increase return-to-work rates for injured employees and whether the predicted savings in compliance costs to businesses have been realised.

Work is also being undertaken by some public service departments to better manage work health and safety, early intervention and return-to-work outcomes through trialling a range of 'best practice' initiatives. These efforts will be monitored and learnings applied to the public service more broadly.